EMPLOYEE BOOKLET

WASHINGTON FIRE COMMISSIONERS ASSOCIATION
PREFERRED HEALTH CARE BENEFITS PLAN

PPO PLAN

THIS BOOKLET CONTAINS
PLAN BENEFITS EFFECTIVE:
January 1, 2004

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PLAN CONTACTS

ELIGIBILITY
See your district administrator for eligibility information

BENEFITS OR CLAIM PAYMENTS
Trusteed Plans Service Corporation ..... (253) 564-5611 or (800) 426-9786

IN-PATIENT HOSPITAL ADMISSIONS
Qualis Health ..... (800) 783-8606

PRESCRIPTION DRUGS
Retail Purchases: Express Scripts ..... (800) 206-4005
Mail Order: Certifax ..... (800) 635-3070

MEDICAL SUMMARY OF BENEFITS

BENEFIT PERIOD	Calendar Year	
	PREFERRED PROVIDER	**NON-PREFERRED PROVIDER**
The Deductible is waived for the following services:		
PREVENTIVE CARE *Limited to a combined maximum of $200 per Calendar Year*		
Routine Physical Exam *Limited to 1 adult exam per Calendar Year*	Covered at 100%	Covered at 70%
Well Child Care	Covered at 100%	Covered at 70%
Immunizations	Covered at 100%	Covered at 70%
OTHER BENEFITS		
Mammogram	Covered at 100%	Covered at 70%
Smoking Cessation Program *Limited to $500 per lifetime*	Covered at 75%	Covered at 75%
DEDUCTIBLE *Applies to the following services:*	Employees: None Dependents: $50 per person, $150 maximum per Family per Calendar Year	
PHYSICIAN SERVICES		
Inpatient	Covered at 100%	Covered at 70%
Outpatient		
Office Visit	Covered at 100%	Covered at 70%
X-ray and Lab	Covered at 100%	Covered at 70%
HOSPITAL SERVICES		
Inpatient		
Room & Board	Covered at 100%	Covered at 70%
Intensive and Coronary Care Units	Covered at 100%	Covered at 70%
X-ray and Lab	Covered at 100%	Covered at 70%
Hospital Miscellaneous Expenses	Covered at 100%	Covered at 70%
Emergency Room	$50 Copayment *, then	$50 Copayment *, then
Services and Supplies	Covered at 100%	Covered at 70%
X-ray and Lab	Covered at 100%	Covered at 70%
Outpatient Department	Covered at 100%	Covered at 70%
MATERNITY & NEWBORN BENEFIT *Employee and Spouse Only*	Covered the same as any other condition.	Covered the same as any other condition.
MASTECTOMY & BREAST RECONSTRUCTION	Covered the same as any other condition.	Covered the same as any other condition.

* Emergency Room Copayment will be waived if the patient is admitted as an Inpatient directly from the Emergency Room.

OTHER BENEFITS	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
Ambulance	Covered at 80%	Covered at 80%
Blood – Processing and administration of blood and blood components	Covered at 80%	Covered at 80%

OTHER BENEFITS	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Chemical Dependency Treatment *Limited to $5,000 per 2 Calendar Years & $10,000 lifetime maximum*	Covered at 100%	Covered at 70%
Chiropractic Care	Covered at 100%	Covered at 100%
Diabetes Care Training	Covered at 100%	Covered at 70%
Durable Medical Equipment & Supplies	Covered at 100%	Covered at 70%
Family Planning	Covered at 100%	Covered at 70%
Hearing Aid Benefit Exam - *Limited to 1 per 24 months* Hardware -*Limited to $700 per 24 months*	 Covered at 100% Covered at 100%	 Covered at 100% Covered at 100%
Home Health *Limited to 130 visits per Calendar Year*	Covered at 100%	Covered at 100%
Hospice *Limited to 6 months per Calendar Year*	Covered at 100%	Covered at 100%
Home Infusion Therapy *Limited to $25,000 per Calendar Year*	Covered at 100%	Covered at 100%
Inpatient Rehabilitative & Cardiac Rehabilitative Care – *Limited to $30,000 per Calendar Year*	Covered at 100%	Covered at 70%
Mental Health Treatment Outpatient - *To 20 visits per Calendar Year* Inpatient - *To 8 days per Calendar Year*	 Covered at 50% Covered at 100%	 Covered at 50% Covered at 70%
Necessary Medical Supplies	Covered at 80%	Covered at 80%
Neurodevelopmental Therapy - *Through age 6* *Limited to $1,000 per Calendar Year*	Covered at 100%	Covered at 70%
Outpatient Physical, Speech & Occupational Therapy & Cardiac Rehabilitative Care *Limited to $1,000 per Calendar Year*	Covered at 100%	Covered at 70%
Skilled Nursing Facility *Limited to 90 days per Calendar Year*	Covered at 100%	Covered at 100%
Temporomandibular Joint Dysfunction *Limited to $1,000 per Calendar Year & $5,000 lifetime maximum*	Covered at 100%	Covered at 70%
Transplant Benefit – *Requires pre-authorization, is subject to the limitations described and is limited to $300,000 per lifetime*	Covered the same as any other condition.	Covered the same as any other condition.
Medically Necessary Eligible Non-Listed Services	Covered at 100%	Covered at 70%

OUT-OF-POCKET MAXIMUM	100% payment when an individual's out-of-pocket expenses for allowable Coinsurance reaches $1,000 in a Calendar Year ($3,000 per Family). Deductibles, Copays and Outpatient Prescription Drugs do not apply to the out-of-pocket maximum.
LIFETIME MAXIMUM BENEFIT	$2,000,000

SUMMARY OF PRESCRIPTION DRUG BENEFITS

	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Retail Purchases 34-day supply* (Express Scripts)		
Generic	$7 Copayment	50% Reimbursement
Brand Name	$10 Copayment**	50% Reimbursement
Retail Purchases 60-day supply (Express Scripts)		
Generic	$14 Copayment	50% Reimbursement
Brand Name	$20 Copayment**	50% Reimbursement
Mail Order 90-day supply (Certifax)		
Generic	$14 Copayment	Not Covered
Brand Name	$20 Copayment	Not Covered

* A 34-day supply or 100 tablets/capsules (whichever is greater) is available for certain maintenance medications for a single Copay. Not all medicines taken on an ongoing basis are part of this benefit - only those on the Maintenance Medication List. Please refer to the Maintenance Medication List, which can be obtained from the Claims Administrator, for other restrictions that may apply.

** This Plan requires that unless your Physician states that a brand name is Medically Necessary, a Generic Drug will be dispensed. If your Physician authorizes a Generic Drug prescription and you elect to receive a Brand Name Drug, you will be required to pay the difference in cost between the Generic Drug and Brand Name Drug, as well as the brand name Copay.

SUMMARY OF VISION BENEFITS

EXAM Limited to one (1) per Calendar Year	Covered at 100%
MATERIALS Limited to $200 per 2 Calendar Years Eyeglass Lenses and Frames AND/OR Contact Lenses	Covered at 80%

NOTE: Prescription Drug and Vision Benefits are not subject to the Calendar Year Medical Deductible.

INTRODUCTION

The Washington Fire Commissioners Association, hereinafter referred to as the "Association" or “WFCA”, as the Plan Sponsor, hereby establishes the benefits, rights and privileges which shall pertain to participating Employees, hereinafter referred to as "Participants" or "Covered Persons", and the eligible dependents of such Participants.

Masculine pronouns used in this document shall include masculine or feminine gender unless the context indicates otherwise. Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

PURPOSE

The purpose of this document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of eligible Medical, Prescription Drug, and Vision expenses. This document will also serve as the Employee booklet.

EFFECTIVE DATE

The effective date of the Plan was January 1, 1999. The Plan was restated on January 1, 2003.

NAMED FIDUCIARY, PLAN SPONSOR AND PLAN ADMINISTRATOR

The Named Fiduciary, Plan Sponsor and Plan Administrator is the Washington Fire Commissioners Association who shall have the authority to control and manage the operation and administration of the Plan. The Washington Fire Commissioners Association has delegated responsibilities for the day-to-day operation and administration of the Plan to Trusteed Plans Service Corporation, as Claims Administrator. The Association shall have the authority to amend the Plan, to determine its policies, to appoint and remove other administrators, fix their compensation (if any), and exercise general administrative authority over them.

The Plan Administrator can, at its discretion, interpret all Plan provisions.

The Named Fiduciary, Plan Sponsor and Plan Administrator is the Association, whose street address and telephone number are: 605 - 11th Ave S.E., Suite 205, Olympia, WA 98501, (360) 943-3880. Address mail to: P. O. Box 134, Olympia, WA 98507.

FINANCING

The amount of contributions to the Plan are to be made on the following basis:

1. The Plan Sponsor shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by participating fire protection districts.
2. Notwithstanding any other provision of the Plan, the Plan Sponsor’s obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Plan Sponsor’s obligation with respect to such payments.
3. In the event that the Plan Sponsor terminates the Plan, then as of the effective date of termination, the participating fire protection districts shall have no further obligation to make additional contributions to the Plan.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment, and in such case shall apply the amount of such payment to or for the benefit of such Participant, his spouse, adult child, guardian of a minor child, or other relative of a dependent of such covered Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan will not be deemed to constitute a contract of employment.

ELIGIBILITY

WHO MAY RECEIVE BENEFITS

The following is a description of the qualifications needed to be eligible.

Employees - Employees of participating fire protection districts working a minimum number of hours per week as designated by the fire protection district and who have met the eligibility waiting period described in "When Coverage Begins".

Ineligible classes of Employees are active LEOFF I personnel (i.e. personnel who were covered by the LEOFF Act prior to October 1, 1977), retired LEOFF I personnel and their dependents, and Fire Commissioners; however, dependents of active LEOFF I personnel will be eligible for coverage under this Plan. Also ineligible are WFCA Staff.

Spouse - Spouse means the lawful spouse of an Employee, unless legally separated or divorced. Common law marriages are not recognized under this Plan. A spouse shall be a "dependent" for purposes of this Plan.

Children - Children include:

Natural, legally adopted or children under legal guardianship - unmarried to their 23rd birthday, if they are dependent on the Employee for support. See the subsection titled "Pre-Adoption Health Coverage" in the "Federal Laws and Regulations" section for information on adopted children.

Step-children - unmarried, to their 23rd birthday, if they are dependent on the Employee and the Employee's Spouse for more than 50% of their support **or** the Employee and the Employee's Spouse are required to provide health benefits pursuant to a court order.

Foster children are not eligible for coverage under this Plan.

Physically or mentally disabled children - unmarried children described above with no age limitation if: 1) they are dependent on the Employee as defined by the IRS, 2) they are unable to be self-supporting because of a permanent physical or mental disability, 3) they are not covered by another group plan, 4) medical verification is submitted as requested, and 5) they were disabled prior to attaining age 23.

A child meeting the definition set forth above shall be a "dependent" under this Plan.

If both the husband and wife are employed by a Participating Fire District, and both are eligible for dependent coverage, both may elect dependent coverage for the eligible dependents and benefits will be processed according to the Coordination of Benefits Provision. Likewise, an Employee may be covered as both an Employee and as a Dependent.

NOTE: SEE ADDITIONAL ELIGIBILITY INFORMATION UNDER THE SECTION ENTITLED "QUALIFIED MEDICAL CHILD SUPPORT ORDER" ON PAGE 21.

EFFECTIVE DATE OF COVERAGE

HOW TO ENROLL

Each participating fire protection district has enrollment forms which should be properly completed within thirty-one (31) days of eligibility.

New dependents of Employees must be enrolled in this Plan within thirty-one (31) days of marriage or other eligibility described in the section titled "Eligibility" (in the case of birth or adoption or placement for adoption, within sixty [60] days of birth or adoption). If coverage for a dependent is not elected when initially eligible, that dependent may only be enrolled as allowed under the Special Enrollment Provisions.

CHANGES IN ENROLLMENT

The Claims Administrator should be notified within thirty-one (31) days if any change occurs which affects eligibility to participate in this Plan.

WHEN COVERAGE BEGINS

Participant Coverage under the Plan shall become effective with respect to a Covered Person on the date of eligibility provided that written application for such coverage is made as provided in this Plan.

New Employees and their eligible dependents will be covered on the Employee's date of hire.

Fire Commissioners and their eligible dependents will be covered on the first of the month following the date of application.

Newborn children, newly adopted children, new spouses or step-children will be covered on the date of birth, adoption, or placement for adoption, marriage or upon meeting the eligibility requirements described in the section titled "Eligibility" if enrollment forms have been properly completed.

All coverage will commence at 12:01 a.m. on the date such coverage is in effect.

SPECIAL ENROLLMENT PROVISIONS

- Loss of Coverage

  A dependent is entitled to enroll in the Plan during a Special Enrollment Period if he meets all of the following requirements:

  1. The dependent is eligible for coverage under the Plan but is not currently covered under the Plan;
  2. The Employee, dependent or another appropriate person, on the dependent's behalf, previously declined to enroll the dependent in the Plan; and
  3. The dependent was covered under an alternative group or other health coverage at the time coverage under this Plan was not elected, and such other coverage is no longer available, for any of the reasons set forth below.

  Coverage (other than COBRA continuation coverage) will be considered no longer available when it terminates because of Loss of Eligibility or termination of Employer contributions toward the cost of such coverage. COBRA continuation coverage will be considered no longer available when the COBRA coverage is exhausted.

  Application must be made within thirty-one (31) days after other coverage ends and must be accompanied by proof of loss of other such coverage. If all other eligibility requirements are met, coverage will be effective the first day following loss of other coverage so that there is no lapse in coverage.

  "Loss of Eligibility" shall mean loss of coverage resulting from legal separation, divorce, death, termination of employment, a reduction in the number of hours of employment, or any loss of eligibility after a period that is measured based on any of those events. Loss of Eligibility shall not mean loss of coverage resulting from an individual's failure to pay premiums on a timely basis or any termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of fact in connection with such coverage.)

- In addition, if you have a new dependent as a result of marriage, birth or adoption or placement for adoption, you may enroll your dependents, provided that you request enrollment within thirty-one (31) days after the marriage and all other eligibility requirements are met (in the case of birth or adoption, within sixty [60] days of birth or adoption or placement for adoption). Coverage will be effective on the date of marriage, birth, adoption or placement for adoption.

- You may also enroll or make coverage selection changes during the annual open enrollment period (provided all other eligibility requirements are met). The annual open enrollment is during the months of November and December for coverage to be effective the following January 1st.

NOTE: The Enrollment Date for anyone who enrolls under a Special Enrollment Provision is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under this Plan and the first day of coverage is not treated as an eligibility waiting period.

ACTIVE EMPLOYEES/SPOUSES AGE 65 OR OVER

Active Employees and/or dependent spouses age 65 or over of Active Employees will receive the same benefits as Employees and dependent Spouses under age 65, unless the individual elects Medicare as the primary payor of health care benefits. If Medicare coverage is selected as primary payor, no benefits will be provided under this Plan.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant Coverage shall automatically terminate immediately upon the earliest of the following dates, except as provided in any COBRA Continuation of Coverage Provision or Family Medical Leave Act (FMLA):

1. On the last day of the month immediately following the date of termination of the Participant's employment or layoff;

2. On the last day of the month immediately following the date the Participant ceases to meet the eligibility provisions of the Plan;

3. On the last day for which contributions were paid, if required contributions for coverage are not remitted;

4. On the date the Plan is terminated;

5. On the date the Participant dies; or

6. On the date the Participant enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days, except as allowed under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

DEPENDENT TERMINATION

The Dependent Coverage of a Participant shall automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month immediately following the date the dependent ceases to be an eligible dependent under the Plan;

2. On the last day of the month immediately following the date of termination of the Participant's coverage under the Plan;

3. On the last day of the month immediately following the date the Participant ceases to meet the eligibility provisions of the Plan;

4. On the last day for which contributions were paid, if required contributions for Dependent Coverage are not remitted;

5. On the date the Plan is terminated;

6. On the last day of the month in which the Participant dies; or

7. On the date the dependent enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days.

FEDERAL LAWS AND REGULATIONS

CONTINUED COVERAGE AFTER TERMINATION (COBRA Continuation of Coverage)

Under a federal law (COBRA), you and your covered Family members have the opportunity for a temporary extension of your group health coverage (called "COBRA continuation coverage") at group rates in certain instances where coverage under this Plan would otherwise end. This notice summarizes your rights and obligations under the COBRA continuation coverage provisions. Both you and your spouse should take the time to read this provision carefully.

WHEN COBRA CONTINUATION COVERAGE IS AVAILABLE - WHEN A QUALIFYING EVENT OCCURS

1. **Employees**: If you are an Employee of a participating fire protection district and you are covered by the Plan, you have a right to elect COBRA continuation coverage if you lose your group health coverage under the Plan for any of the two following qualifying events:

   a) A reduction in your hours of employment; or
   b) The termination of your employment (for reasons other than gross misconduct).

2. **Spouses:** If you are the spouse of an Employee covered by the Plan, you have the right to elect COBRA continuation coverage for yourself if you lose your group health coverage under the Plan for any of the following four qualifying events:

   a) The death of your spouse;
   b) The termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment;
   c) Divorce or legal separation from your spouse; or
   d) Your spouse becomes entitled to Medicare benefits under Title XVIII of the Social Security Act.

3. **Dependent Child:** A dependent child of an Employee covered by the Plan has the right to elect COBRA continuation coverage if the dependent child's group health coverage under the Plan is lost for any of the following five qualifying events:

   a) The death of the Employee-parent;
   b) The termination of the Employee-parent's employment (for reasons other than gross misconduct) or reduction in the Employee-parent's hours of employment;
   c) The parents' divorce or legal separation;
   d) The Employee-parent becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or
   e) The dependent ceases to be a "dependent child" under the Plan.

4. **Newborn or Newly Adopted Child:** If a child is born or adopted by the covered Employee during the period of COBRA continuation coverage, and the covered Employee has elected COBRA continuation coverage, then the Employee (or other guardian) may elect COBRA continuation coverage for the child.

ELECTING COBRA CONTINUATION COVERAGE

Under the law, the covered Employee or a covered Family member has the responsibility to inform the Employer of the Employee's divorce or legal separation, or a child's losing dependent status under the Plan. This notice must be given to the Employer within sixty (60) days after the later of (1) the date of such an event, or (2) the date on which the affected Employee or Family member would otherwise lose coverage because of such event. If this notice is not given to the Employer within the required 60-day period, the affected Employee or Family member will not be entitled to elect COBRA continuation coverage. The Employer has the responsibility to notify the Claims Administrator of the Employee's death, the Employee's termination of employment or reduction in hours, or the Employee's becoming entitled to Medicare under Title XVIII of the Social Security Act.

When the Claims Administrator is notified that one of these qualifying events has occurred, the Claims Administrator will in turn notify the appropriate individuals (also called "qualified beneficiaries") that they have the right to elect COBRA continuation coverage. COBRA continuation coverage must be elected by such individuals within sixty (60) days after the later of (1) the date that coverage under the Plan would otherwise terminate due to the qualifying event, or (2) the date that these individuals are provided with written notification of their right to elect COBRA continuation coverage. If COBRA continuation coverage is not elected within this 60-day period, the Plan coverage will end retroactive to the date that coverage would have otherwise ended due to the COBRA qualifying event, and the affected Employee or Family member will not be entitled to elect COBRA continuation coverage. While an election by a covered Employee or covered spouse will be treated as an election of COBRA continuation coverage by the entire Family, each Family member may make a separate election as to COBRA continuation coverage. This means that a covered spouse or dependent child may elect COBRA continuation coverage even if the Employee does not make that election. If a child is born to, or placed for adoption with, a covered former Employee during the COBRA continuation coverage period and the covered Employee has elected COBRA continuation coverage, then the Employee may elect COBRA continuation coverage for that child provided that the covered former Employee notifies the Claims Administrator within the Plan's normal enrollment window for Newborn children, adopted children, or children placed for adoption. You (or your covered spouse or

dependents) may elect COBRA continuation coverage even if you (or your covered spouse or dependents) are covered under another group health plan or are entitled to Medicare prior to electing COBRA continuation coverage.

EXTENT OF COVERAGE

If continuation of coverage is elected, the Employer is required to provide COBRA continuation coverage which, at the time that coverage is being provided, is identical to the coverage provided under the Plan to similarly situated Plan Participants who have not experienced a qualifying event (called "non-COBRA beneficiaries"). For example, if an Employee dies leaving a spouse and two dependent children covered under the Plan, they would be entitled to the same benefits as the covered spouse and dependent children of an active Employee. If the benefits for similarly situated non-COBRA beneficiaries are modified, the changes will apply to those who have COBRA continuation coverage as well.

COBRA continuation coverage may be maintained for up to 36 months unless the group health coverage was lost due to the Employee's termination of employment or a reduction in hours. In these two situations, COBRA continuation coverage may be maintained for up to 18 months. However, if the Social Security Administration determines that the covered Employee, spouse or dependent child was disabled at any time during the first sixty (60) days of COBRA continuation coverage and such individual provides the Claims Administrator with a copy of that determination within sixty (60) days after it is made and before the 18-month period expires, then that 18-month coverage may be extended for an additional 11 months (for a total of 29 months after the date the COBRA continuation coverage began) for the disabled Qualified Beneficiary and other covered Family members. In the case of a child born to, or placed for adoption with, a covered Employee during the period of COBRA continuation coverage, the 60-day period (mentioned in the previous sentence) is measured from the child's date of birth or placement for adoption. Each covered Employee or covered Family member who is determined to be disabled (under Title II or XVI of the Social Security Act) at any time during the first 60 days of COBRA continuation coverage has the responsibility to: (1) inform the Claims Administrator within sixty (60) days after the date of that determination, and (2) if applicable, inform the Claims Administrator within thirty (30) days after the date of any final determination that the covered Employee or covered Family member is not disabled.

Covered Dependents who were covered by the Plan prior to the Employee's termination of employment or reduction in hours and who are receiving COBRA continuation coverage, and any child born to the covered Employee or placed with the covered Employee for adoption and enrolled in the Plan while the covered Employee is receiving COBRA continuation coverage, will be eligible to extend the initial 18-month COBRA continuation period (or if applicable, the 29-month COBRA continuation period) if one of the following events occurs during that 18-month period (or if applicable, the 29-month COBRA continuation period):

1. the covered Employee's death;
2. the covered Employee's divorce or legal separation;
3. the covered Employee becomes entitled to Medicare benefits; or
4. a dependent child ceases to be a dependent under the terms of the Plan.

In any of the four situations described above, the Covered Dependents may extend their COBRA continuation coverage for up In any of the four situations described above, the Covered Dependents may extend their COBRA continuation coverage for up to 36 months from the date the covered Employee terminated employment or lost Plan coverage because his hours were reduced. The covered Employee or a covered Family member must inform the Claims Administrator of the Employee's divorce or legal separation, or a child's losing dependent status under the Plan, within 60 days after the occurrence of such event. A Family member whom the covered Employee first enrolls during an annual enrollment period or special enrollment period while the covered Employee is receiving COBRA continuation coverage is not eligible to extend the COBRA continuation period as described in this paragraph, unless that Family member is a child born to the covered Employee or placed with the covered Employee for adoption and enrolled in the Plan while the covered Employee is receiving COBRA continuation coverage.

If a covered Employee becomes entitled to Medicare while employed by a participating fire protection district, and within eighteen (18) months after the Employee becomes entitled to Medicare, he loses group health plan coverage due to the Employee's termination of employment or reduction in hours, then the Employee's covered dependents may elect COBRA continuation coverage for a period beginning with that loss of coverage and ending 36 months after the date the Employee became entitled to Medicare.

In general, you and your covered dependents (if any) will only be given an opportunity to continue the coverage you each were receiving immediately before the qualifying event. In a few circumstances, however, you may elect alternative coverage that the Employer makes available to active Employees, such as:

1. You participate in a region-specific HMO that will not service your health needs in the area to which you are relocating, you must be given an opportunity to elect alternative coverage that the Employer makes available to active Employees.

2. You and your covered dependents (if any) will have the same opportunity as an active Employee to change your coverage at annual enrollment, add new Family members, or drop dependents.

3. A Qualified Beneficiary who has elected COBRA continuation coverage may elect to cover certain Family members under special enrollment rights if certain requirements are satisfied.

In general, there are special enrollment rights for certain Family members upon the loss of other group health plan coverage or upon the acquisition by the Employee or Participant of a new spouse or of a new dependent through marriage, birth, adoption, or placement for adoption. Please refer to the appropriate section of this Plan for further details on those special enrollment rights. Please note that a Family member whom you first enroll during an annual enrollment period or special enrollment period while you are receiving COBRA continuation coverage and who was not covered by the Plan on the day before the initial COBRA qualifying event occurred is not eligible to extend the initial COBRA continuation period as described in this notice, unless that Family member is a child born to the covered Employee or placed with the covered Employee for adoption during the initial 18-month period of COBRA continuation coverage and enrolled in the Plan while the covered Employee was receiving COBRA continuation coverage.

WHEN COBRA CONTINUATION COVERAGE ENDS

The law provides that COBRA continuation coverage will be cut short for any of the following reasons:

1. The Employer no longer provides group health coverage to any of its Employees;

2. The premium for the COBRA continuation coverage is not paid on a timely basis (the first premium payment is payable in a lump sum forty-five (45) days after electing COBRA continuation coverage; all subsequent premium payments are payable within thirty (30) days after the due date);

3. The covered individual first becomes, after the date of the COBRA continuation coverage election, covered under another group health plan (as an Employee or otherwise) that does not contain any exclusion or limitation with respect to any Pre-Existing Condition of that individual (other than an exclusion or limitation that does not apply to, or is satisfied by, such individual by reason of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"));

4. The covered individual first becomes, after the date of the COBRA continuation coverage election, entitled to Medicare (under Title XVIII of the Social Security Act);

5. When coverage has been extended from 18 to 29 months, the Social Security Administration makes a final determination that an individual is no longer disabled (under Title II or XVI of the Social Security Act); or

In the case of the event listed in number (5) above, a disabled individual is required to inform the Claims Administrator within thirty (30) days after the date of any final determination that the covered Employee or covered Family member is not disabled. Covered individuals must notify the Claims Administrator if an event occurs that is listed in number (3) or (4) above within thirty (30) days after becoming eligible for such other group health plan coverage or entitled to Medicare.

COST OF COBRA CONTINUATION COVERAGE

The cost of COBRA continuation coverage will generally not exceed 102% of the cost to the Plan Sponsor for coverage under the Plan. The cost of COBRA continuation coverage will increase in the middle of the 12-month determination period only in the following instances:

1. Where coverage extends beyond 18 months for a disabled individual, the cost of COBRA continuation coverage will be 150% of the applicable premium,

2. Where the Qualified Beneficiary changes to more expensive coverage, or

3. Where the Plan was previously requiring payment of less than the maximum permissible amount.

An individual seeking COBRA continuation coverage is liable for the cost of that coverage during the entire applicable 18-, 29-, or 36-month period (measured from the date that coverage would otherwise end due to the qualifying event). Due to the required sixty (60) day COBRA election period, it is likely that a covered individual will be responsible for retroactive premiums. These premiums must be paid in a lump sum within forty-five (45) days after electing COBRA continuation coverage in order for the COBRA continuation coverage to be effective. After that payment, premiums are due on a monthly basis. Coverage will terminate if premiums are not paid within thirty (30) days after the date they are due.

An individual need not show proof of insurability to elect COBRA continuation coverage.

If an individual is eligible for trade adjustment assistance, the following information will apply:

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have a question about these new tax provisions, you may call the “Health Care Tax Credit Customer Contact Center” toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

COBRA CONTINUATION QUESTIONS

If you have any questions about the law, please contact the Employer. This notice is merely a summary of the law. The law is part of the Consolidated Omnibus Budget Reconciliation Act of 1985. If a conflict exists between this notice and the exact terms of the law, the terms of the law will control.

UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

It is the intent of this Plan to comply with all provisions of the Uniform Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Employees going into or returning from military service may elect to continue Plan coverage as mandated by USERRA. These rights apply only to eligible Employees and eligible dependents covered under the Plan before leaving for military service.

The maximum period of coverage of a person under such an election shall be the lesser of:

a. The 18-month period beginning on the date that Uniformed Service leave commences; or

b. The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

A Preexisting Condition limitation may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, Plan Exclusions and waiting periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

There are time limits for reporting back to work upon release from the military as well as notice requirements. For further details, please contact the Employer.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

Under the FMLA, eligible Employees are entitled to an unpaid leave of absence for up to twelve (12) weeks (spouse of Employees who are also Employees of the same fire protection district are eligible for a maximum combined total of twelve (12) weeks leave under this act) within a twelve (12) month period, provided the leave is for:

1. the birth of a son or daughter or to provide care for the Newborn;
2. the placement with the Employee of a son or daughter for adoption or foster care;
3. a "serious health condition" of the Employee's spouse, son, daughter or parent; or
4. a "serious health condition" of the Employee that makes the Employee unable to perform the function of his job.

A "serious health condition" exists whenever an Illness, Injury, impairment or mental condition involves Inpatient care or continuing care by a healthcare provider, as defined in Section 825.114 of the Family and Medical Leave Act of 1993.

An Employee is considered eligible, if:

1. the Employee has worked for the district for at least twelve (12) consecutive months, and
2. has been employed for at least 1,250 hours of service during the twelve (12) month period immediately preceding the commencement of the leave, and
3. is employed at a work-site with fifty (50) or more Employees within a seventy-five (75) mile radius at other work-sites of the Employer.

The twelve (12) month period is based on a twelve (12) month period measured forward from the date any Employee's first FMLA leave begins.

Generally, leave must be taken all at once. However, under certain circumstances, the leave may be taken intermittently or on a reduced leave schedule. If the leave is taken because of a birth or placement of a child for adoption or foster care, an Employee may take leave intermittently or on a reduced schedule only if the Employer agrees.

Prior to taking family leave, Employees must give the Employer at least thirty (30) days advance notice of the intended leave dates or as much notice as is practical, whichever is less. In addition, the Employee may be required to provide certification for the Medical Necessity of the leave.

The FMLA requires the Employer to continue group coverage during the FMLA leave. If the coverage is contributory, the Employee's share of the premiums will be due at the same time they would be made if by payroll deduction. Coverage will terminate if the Employee does not make the required premium contributions for coverage (if any) within thirty (30) days of the premium due date as described above.

Employees returning from leave as described under FMLA, and who choose not to continue their coverage, will have their coverage reinstated to the same level of benefits as if the leave had not taken place, or if the premium payments had not been missed. The Employee will not be required to satisfy a new waiting period or new Pre-Existing Condition Waiting Period.

This is a summary of the FMLA rules. For more information, contact your Employer.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Claims Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an eligible dependent, once the Claims Administrator has determined that such order meets the standards for qualification set forth below.

"Alternate Recipient" shall mean any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible dependent.

"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";

2. a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Claims Administrator will assume that all are designated;

   b. Informs the Claims Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Beneficiaries without regard to this Section 4.05, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Claims Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Claims Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

   a. Whether the child is covered under the Plan; and
   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Claims Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

PRE-ADOPTION HEALTH COVERAGE

A child under the age of eighteen (18) is eligible for coverage from the time the child is placed for adoption in the home of a Plan Participant, and shall be treated in the same manner as a natural child of a Participant, even if the adoption has not become final.

COINSURANCE

The percentage share payable by you on claims for which the Plan provides benefits at less than 100% of the allowed amount.

DEDUCTIBLE

The deductible is the dollar amount of Covered Expenses (shown in the Medical Summary of Benefits) which must be incurred during the Calendar Year before any other Covered Expenses can be considered for payment (unless otherwise noted).

DEDUCTIBLE CARRYOVER PROVISION

Covered Expenses incurred during the last three (3) months of a Calendar Year which are applied to a deductible will be "carried over" and applied against any deductible applicable in the following Calendar Year.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan Administrator reserves the right to allocate any applicable deductible amount to any eligible charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

COMMON ACCIDENT PROVISION

If two (2) or more members of the same Family receive Injuries in the same accident and, as a result of those Injuries, incur Covered Expenses during the same Benefit Period in which the accident occurs, only one Medical Plan Deductible amount will be deducted from the total eligible expenses incurred.

OUT-OF-POCKET MAXIMUM

The coinsurance that you are required to pay for medical services and supplies received is subject to an annual out-of-pocket maximum (shown in the Medical Summary of Benefits). Deductibles, Copayments and Outpatient prescription drugs DO NOT apply to the out-of-pocket maximum and do not increase to the 100% benefit level. Additionally, non-covered services and expenses you may incur over the maximum allowable amounts covered by the Plan will not apply to your out-of-pocket maximum.

LIFETIME MAXIMUM BENEFIT & AUTOMATIC RESTORATION/REINSTATEMENT OF MAXIMUM BENEFIT

The total medical expense benefits payable for a Covered Person under this Plan shall not exceed the Lifetime Maximum Benefit of $2,000,000 even though they may not have been continuously covered.

If less than the full Lifetime Maximum Benefit applicable to the Covered Person is available as of January 1st of each year (as a result of benefits paid or payable with respect to charges previously incurred), the used portion of the Lifetime Maximum Benefit shall automatically be restored to the extent of: (1) The amount needed to restore the full Lifetime Maximum Benefit applicable to the Covered Person, or (2) Twenty thousand dollars ($20,000.00), whichever is less. Benefits listed with a separate lifetime maximum (Transplants, Chemical Dependency Treatment, Smoking Cessation, and Temporomandibular Join Dysfunction) do not restore under this provision.

LOCATING A PREFERRED PROVIDER

To locate a Preferred Provider, refer to your Plan ID card. You may contact the Preferred Provider Network directly, or contact the Claims Administrator.

LOCATING A MEMBER PHARMACY

To locate a member pharmacy, refer to your Plan ID card. You may contact the pharmacy benefit manager directly, or contact the Claims Administrator.

BENEFITS PROVIDED BY YOUR MEDICAL PROGRAM

In order to be eligible for benefits under this provision, expenses actually incurred by a Covered Person must meet all of the following requirements:

1. They are ordered by a Physician and administered by a Physician And/Or Licensed Health Care Provider;

2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury unless otherwise specifically included as a Covered Expense; and

3. They are not excluded under any provision or section of this Plan.

Covered Expenses include the following and are payable as outlined in the Medical Summary of Benefits:

BENEFITS NOT SUBJECT TO THE ANNUAL DEDUCTIBLE:

I. Preventive Care

A. Routine physical exam, related laboratory services and immunizations for children. All charges are subject to the annual preventive care benefit allowance as shown in the Medical Summary of Benefits.

B. Routine adult physical exam, including charges for x-ray, lab and immunizations associated with the routine exam, subject to the annual preventive care benefit allowance as shown in the Medical Summary of Benefits.

C. Routine gynecological exams, including charges for x-ray and lab associated with the gynecological exam, subject to the annual preventive care benefit allowance as shown in the Medical Summary of Benefits.

II. Other Benefits

A. Screening and diagnostic mammogram services.

B. The services of a Physician, Psychologist, or smoking cessation provider will be provided for a smoking cessation program, to the lifetime maximum as shown in the Medical Summary of Benefits. To receive benefits for smoking cessation, you must complete the full course of treatment. No benefits will be provided for Inpatient services; vitamins, minerals and other supplements; acupuncture; books or tapes; or hypnotherapy unless performed by a licensed provider. No other benefits for smoking cessation will be provided under this Plan. However, over-the-counter drugs prescribed by your covered provider to ease nicotine withdrawal will be covered, subject to the lifetime maximum, if part of a smoking cessation program and you complete the full course of treatment. Prescription drugs are covered under the prescription drug benefit of this Plan.

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BENEFITS AFTER SATISFACTION OF THE ANNUAL DEDUCTIBLE

Deductible is applicable for dependents.

III. Physicians Services

Inpatient and Outpatient visits, surgical care, allergy shots, chemotherapy, x-ray, radium or diagnostic x-ray and laboratory services.

IV. Hospital Charges

Charges made by a Hospital, for:

A. Daily Room and Board and general nursing services, or confinement in an Intensive Care Unit. Room and Board (other than coronary care unit and Intensive Care Unit) is limited to the Hospital's average Semi-Private room rate. If a facility has only private rooms, the Plan will determine benefits based on the average charges of other facilities in the area (according to UCR).

B. Medically Necessary services and supplies other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions, Emergency room services, physical therapy treatments, hemodialysis, and x-ray and linear therapy.

V. Maternity & Newborn Care Benefit

A. Routine obstetrical/maternity benefits, including termination of Pregnancy and Cesarean surgeries, will be provided for Employees and covered spouses only. Included in this benefit are charges for a birthing center. Maternity benefits are not subject to any Pre-Existing Condition Waiting Period contained in this Plan.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or Newborn's attending provider, after consulting with the mother, from discharging the mother or her Newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Dependent children are not eligible for benefits under this provision, except for charges incurred due to complications arising from Pregnancy.

Benefits are also not provided for pregnancies that are the result of, or for the purposes of, surrogate maternity.

B. Medical facility charges incurred by a well Newborn during the initial period of confinement (48 hours or 96 hours, as outlined above) will be covered as charges of the baby. This benefit includes, within the first 96 hours following birth, the medical facility nursery expenses for a healthy Newborn, routine pediatric care for a healthy Newborn child while confined in a Hospital or medical facility immediately following birth, and Phenylketonuria (PKU) testing.

If the baby is ill, suffers an Injury, premature birth, congenital abnormality or requires care other than initial routine care, benefits will be provided on the same basis as for any other eligible expense, provided the child is properly enrolled and coverage is in effect.

VI. Mastectomy and Breast Reconstruction Services

Benefits are provided for mastectomy Medically Necessary due to Illness or accidental Injury. For any Covered Person electing breast reconstruction in connection with a mastectomy, this benefit covers:

A. Reconstruction of the breast on which mastectomy has been performed.

B. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

C. Prostheses.

D. Physical complications of all stages of a mastectomy, including lymphedemas.

Services are to be provided in a manner determined in consultation with the attending Physician and the patient.

VII. Chemical Dependency Treatment

Chemical Dependency Treatment includes Room and Board, general nursing care and other services and supplies furnished by an Alcoholism Treatment Center or Drug Addiction Treatment Facility for Medically Necessary Inpatient or Outpatient treatment, up to the stated benefit limits as shown in the Medical Summary of Benefits.

No benefits will be provided for recovery houses, residential crisis treatment centers or residential treatment facilities which provide an alcohol-free or drug-free residential setting or for Emergency service patrol.

VIII. Hearing Aid Benefit

Charges incurred for treatment relating to hearing loss, including examinations, hearing aid(s), ear mold(s), and necessary repairs, up to the stated benefit limits as shown in the Medical Summary of Benefits. To be eligible for this benefit, the patient must be examined within three (3) months prior to obtaining the hearing aid and submit written Physician certification of hearing loss to the Claims Administrator.

Charges for hearing aids that do not meet professionally accepted standards of practice, including charges for services or supplies that are experimental in nature are not covered. Additionally, replacement of hearing aids that are lost, broken or stolen are not covered unless three years have elapsed since the initial purchase of the hearing aid.

IX. Home Health Care

Charges made by a Home Health Care Agency for care in accordance with the written Home Health Care Plan filed by the attending Physician with the Claims Administrator. Such expenses, up to the stated benefit limits as shown in the Medical Summary of Benefits, include:

A. Part-time or intermittent nursing care by a Registered Nurse or by a Licensed Practical Nurse, a vocational nurse,

or public health nurse who is under the direct supervision of a Registered Nurse.

B. Home health aides;

C. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if the Covered Person had remained in the Hospital.

Specifically excluded from coverage under this benefit are the following:

A. Services and supplies not included in the Home Health Care Plan.
B. Services of a person who ordinarily resides in the home of the Covered Person, or is a Close Relative of the Covered Person.
C. Services of any social worker.
D. Transportation services.

X. Hospice

Charges made by a Hospice will be considered for a Covered Person who is in the latter stages of a terminal Illness and who is homebound, and would otherwise require hospitalization.

The following services, up to the stated benefit limits as shown in the Medical Summary of Benefits, will be considered Covered Expenses:

A. Nursing care by a Registered Nurse or by a Licensed Practical Nurse, a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse

B. Physical therapy and speech therapy when rendered by a licensed therapist.

C. Medical supplies, including drugs and biologicals and the use of medical appliances.

D. Physician's services.

E. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

F. Respite care will be provided up to a maximum of 5 days per 3-month period of Hospice care.

XI. Mental Health Care

Benefits are limited to neuropsychiatric disorders and include only those disorders listed in the International Classification of Diseases as psychoses, neuroses, personality disorders, and other non-psychotic mental disorders. Treatment for eating disorders include anorexia nervosa and bulimia only.

XII. Skilled Nursing Facility

Charges made by a Skilled Nursing Facility for the following services and supplies furnished by the facility, up to the Semi-Private rate. Only charges incurred in connection with convalescence from the Illness or Injury for which the Covered Person is confined will be eligible for benefits. Such confinement must commence within fourteen (14) days of being discharged from a Hospital; said Hospital confinement must have been for a period of not less than three (3) consecutive days; and both the Hospital and convalescent confinements must have been for the care and treatment of the same Illness or Injury. These expenses include:

A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area.

B. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians' fees.

C. Drugs, biologicals, solutions, dressings and casts, furnished for use during the convalescent period.

XIII. Transplant Benefit

All transplants must be pre-authorized; that is, the Plan conditions receipt of transplant benefits on approval of the benefit in advance of obtaining medical care. Contact the Claims Administrator prior to undergoing any transplant procedure. Services and supplies in connection with transplant procedures are covered up to the stated benefit maximum as shown in the Medical Summary of Benefits, subject to the following conditions:

A. Only human tissue-to-tissue transplants will be considered as eligible for coverage under the Plan. The following

transplant procedures will be considered as covered: cornea, heart, heart/lung combined, kidney, kidney/pancreas combined, liver, lungs (single/bilateral/lobar). All other transplant procedures, including experimental, investigational, non-human organ or artificial organ implant procedures, are specifically excluded. No benefits will be provided for selective islet cell transplants of the pancreas, transplant of a lung or other organ (except kidney) from a living donor unless such donor has been declared brain dead by the attending provider.

B. Allogenic (related or unrelated) bone marrow transplants will be provided, limited to the following malignancies or conditions: acute leukemias (lymphocytic or non-lymphocytic), chronic myelogenous leukemia, aplastic anemia, lymphoma (Hodgkin and Non-Hodgkin), neuroblastoma state III and IV in children over one year of age, or multiple myeloma.

Autologous (self-donor) bone marrow transplants or stem cell support will be provided, limited to the following malignancies or conditions: Lymphoma (Hodgkin or Non-Hodgkin), neuroblastoma, acute leukemias (lymphocytic or non-lymphocytic) or multiple myeloma. Bone marrow transplants and stem cell support for other conditions will not be covered.

Services and supplies related to removal and treatment of the bone marrow and the hospitalization from the day of bone marrow infusion until the patient is discharged will be applied toward the stated benefit maximum as shown in the Medical Summary of Benefits.

C. Prior to undergoing any transplant procedure, a second opinion must also be obtained and submitted to the Claims Administrator as part of the pre-authorization process. This mandatory second opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

D. If the donor is covered under this Plan, Covered Expenses incurred by the donor will be eligible for benefits.

E. If the recipient is covered under this Plan, Covered Expenses incurred by the recipient will be eligible for benefits. Expenses incurred by the donor, who is not ordinarily covered under this Plan according to Participant eligibility requirements, will be considered Covered Expenses, to the extent that such expenses are not payable by the donor's plan, up to $25,000. Any donor benefit will be charged against the recipient's stated benefit maximum as shown in the Medical Summary of Benefits.

F. If both the donor and the recipient are covered under this Plan, Covered Expenses incurred by each person will be treated separately for each person.

G. The reasonable and customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered Covered Expenses.

H. Transportation and lodging, for you and your Family will be covered when you are required to travel 30 miles or more from your home in conjunction with a covered transplant procedure, up to $2,500 per transplant.

I. Transplants will not be covered unless the Covered Person has been covered by this Plan and/or the prior Association-sponsored plan for twelve (12) consecutive months, whether or not the condition is a Pre-Existing Condition or an Emergency.

XIV. Other Benefits

A. Charges for professional Ambulance service to the nearest facility equipped to treat the specific Illness or Injury.

B. Services of a chiropractor if the service is within the lawful scope of the chiropractor's license.

C. Treatment or services rendered by a licensed physical therapist on an Outpatient basis, subject to the limits as shown in the Medical Summary of Benefits. This includes fees of a legally qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an Illness or Injury, other than a functional nervous disorder, or due to surgery performed on account of an Illness or Injury. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy. Massage therapy performed by a licensed physical therapist will be considered Covered Expenses if treatment is part of and secondary to an ongoing physical therapy treatment plan.

If you had an Inpatient rehabilitative admission for the condition and did not exhaust your Inpatient benefit limit as shown in the Medical Summary of Benefits, you may apply to the Claims Administrator for additional Outpatient benefits beyond the stated limit. Limited extensions may be granted up to the balance of the unused Inpatient benefit if the services are determined to be Medically Necessary.

D. Reasonable charges up to the stated benefit limits as shown in the Medical Summary of Benefits for rehabilitative physiatric therapy when performed by a licensed physical or occupational therapist within the scope of their license, in an acute care Inpatient setting, when Medically Necessary as prescribed by a Physician to assist in the use of and recovery of use of limbs. Inpatient provider services that are primarily for the purpose of rehabilitation will be provided the same as any other Inpatient treatment. Such services must occur within 36 months of the date of Injury or onset of Illness.

E. Charges for Inpatient and Outpatient x-rays, microscopic tests, and laboratory tests.

F. Charges for the following services:

1. Radiation therapy or treatment.

2. The processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.

3. Oxygen and other gases and their administration.

4. Diabetes care training; including self-management training and education, including nutritional therapy, if recommended by an approved provider with expertise in diabetes.

5. The cost and administration of an anesthetic.

6. Necessary medical supplies, such as dressings, sutures, casts, splints, trusses, crutches, braces, and orthotics, with the exception of dental braces or corrective shoes.

7. Neurodevelopmental therapy for children through age 6 up to the stated benefit limit as shown in the Medical Summary of Benefits. This includes services and supplies for learning disabilities in cases where significant deterioration would result without such services or supplies.

8. Charges for home infusion therapy up to the stated benefit limit as shown in the Medical Summary of Benefits.

9. Charges for PKU formula. This benefit is not subject to any Pre-Existing Condition Waiting Periods.

G. Durable Medical Equipment and Supplies:

1. The rental (up to the purchase price, including sales tax) of wheelchairs, Hospital beds, respirators or other Durable Medical Equipment required for temporary therapeutic use, or the purchase (including sales tax) of this equipment if economically justified, whichever is less.

   NOTE: Items that may be useful to persons in the absence of Illness or Injury, such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, hot tubs, spas, dehumidifiers, exercise equipment, health club memberships, etc., are not included, whether or not they have been prescribed or recommended by a Physician.

2. Artificial limbs, eyes or larynx, Orthopedic Appliances, or other Prosthetic Appliances.

For repairs or replacements of Durable Medical Equipment and Supplies, you must have:

a. The attending Physician's prescription; and
b. A written explanation from the Physician as to why repair or replacement is necessary; and
c. An itemized repair or replacement cost statement.

For repairs, the Plan will pay up to the maximum which would be allowed for replacement of the equipment.

NOTE: No benefit is provided for cosmetic prostheses (except as provided for under the Mastectomy and Breast Reconstruction benefits of this Plan).

H. Services for voluntary sterilization for Participants and dependent spouses are covered as indicated in the Medical Summary of Benefits under “Family Planning”. Reversal of these procedures is not covered.

I. Charges made by an Ambulatory Surgical Center or Minor Emergency Medical Clinic when treatment has been rendered.

J. Services for the treatment of Temporomandibular Joint dysfunction by a Physician or licensed Dentist. These benefits are limited as shown in the Medical Summary of Benefits. Services received from a licensed Dentist are limited to Usual, Customary and Reasonable and are payable at the Preferred Provider benefit level.

The following services are not included in the Temporomandibular Joint Dysfunction benefit: (a) restorative techniques to provide for proper occlusion, unless the tooth is diseased or accidentally damaged and (b) orthodontic treatment.

K. Charges for surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or any other similar state statutes requiring such surcharges will be considered Covered Expenses by this Plan. Local, state and federal taxes associated with supplies or services covered under this Plan will also be considered Covered Expenses by this Plan.

MEDICAL PLAN LIMITATIONS AND EXCLUSIONS

The following Exclusions and Limitations apply to expenses incurred by all Covered Persons:

1. Charges incurred prior to the effective date of coverage under the Plan, or after coverage is terminated;

2. Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country. An act of terrorism will not be considered an act of war, declared or undeclared;

3. An Illness, Injury or condition arising out of or in the course of employment or charges for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law, or any such similar law (this includes any occupational Injury or disease arising out of self-employment);

4. Charges incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage;

5. Charges resulting from treatment of Injuries or Illnesses received while committing or attempting to commit a felony;

6. Charges for vitamins, nutritional supplements, or devices not Medically Necessary (as determined by the Plan) for the treatment of an Injury or Illness, unless specifically provided;

7. Charges incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or in connection with Custodial Care, education or training expenses actually incurred by other persons, or occupational therapy except as otherwise noted in this Plan;

8. Charges incurred in connection with the care or treatment of, or surgery performed for, a Cosmetic Procedure, unless made necessary:

   a) By an accidental Injury.
   b) When rendered to correct a congenital anomaly, i.e., a birth defect, for a covered dependent.
   c) For reconstructive surgery as necessary for the prompt treatment of a diseased condition.
   d) By reconstructive breast surgery that is in connection with a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit of this Plan.

9. Charges incurred in connection with services and supplies which are not Medically Necessary for treatment of Injury or Illness or are in excess of Usual, Customary and Reasonable (UCR) charges as determined by the Plan, or are not recommended and approved by a Physician, unless specifically shown as a Covered Expense elsewhere in the Plan;

10. Charges for services, supplies or treatments not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value, unless specified as a Covered Expense elsewhere in the Plan;

11. Charges for services rendered by a Physician and/or Licensed Health Care Provider if such is a Close Relative of the Covered Person, or resides in the same household of the Covered Person;

12. Charges incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies;

13. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or occurring in an institution which is primarily a place for the treatment of chronic or long-term Injuries or Illnesses;

14. Charges for Physicians' fees for any treatment which is not rendered by or in the physical presence of a Physician;

15. Except as specifically provided, charges incurred in connection with the purchase or fitting of eyeglasses, contact lenses or such similar aid devices. This exclusion includes visual analysis, therapy or training, orthoptics;

16. Charges incurred for dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or Alveolar processes. However, benefits will be payable for treatment required because of accidental bodily Injury to natural teeth sustained while covered (unless otherwise required by applicable law). Benefits for that Injury will be covered for six (6) months following the date of the Injury. This exception shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture;

17. Charges associated with impotency (except for Medically Necessary treatment when there is an underlying medical condition), infertility, and procedures to restore fertility or to induce Pregnancy, including but not limited to: corrective or reconstructive surgery; hormone injections; in-vitro fertilization; artificial insemination; gamma intra-fallopian transfer (G.I.F.T.) and penile implants;

18. Charges for professional services on an Outpatient basis in connection with mental Illness, Alcoholism, drug addiction, functional nervous disorders, mental and nervous disorders of any type or cause, that can be credited toward earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis, or alcohol and drug treatment that is required as a result of a court order;

19. Charges for Psychiatric Care or psychological counseling for marital, occupational, recreational, milieu or group therapy or counseling; or for education or training services, including but not limited to: vocational assistance, outreach, non-medical self-help such as “Outward Bound” or “Wilderness Survival”; social or cultural therapy; gym or swim therapy; work hardening; exercise; maintenance-level programs; and family, social, sexual, lifestyle, nutritional, and fitness counseling, unless specifically provided;

20. Charges resulting from or in connection with the reversal of a sterilization procedure;

21. Charges for Experimental and/or Investigational procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States;

22. Charges incurred in connection with services or supplies provided for the treatment of obesity and weight reduction (regardless of diagnosis) or the reversal of such procedures;

23. Travel expenses whether or not recommended by a Physician, or travel expenses incurred by a Physician attending a Covered Person, or travel expenses of a person accompanying a Participant, except as specifically provided under the Transplant Benefit;

24. Charges for missed or cancelled appointments; for telephone consultations; mailing and/or shipping and handling expenses; expenses for preparing medical reports, itemized bills or claim forms but not expenses incurred by the Plan for utilization review, audits or investigation of a claim for benefits if approved by the Plan;

25. Charges for acupuncture, naturopathy, holistic medical procedures, massage therapy or rolfing, unless specifically provided;

26. Hair transplant procedures, wigs, artificial hair pieces or drugs which are prescribed to promote hair growth;

27. Charges for diagnosis or any services, care or treatment for sexual dysfunction, trans-sexualism, gender dysphoria or sexual reassignment, including drugs, medications, surgery, medical or Psychiatric Care or treatment;

28. Services related to radial keratotomy or any vision procedure or hardware designed to correct any refractive error;

29. Charges for Hospital care for dental procedures;

30. Charges for Injuries related to semiprofessional or professional athletics, including practice;

31. Charges for hospitalization for minor conditions such as common colds, removal of small tumors, etc. unless such hospitalization is deemed Medically Necessary by the Plan;

32. Charges incurred as a result of a self-inflicted Injury or charges for any Injury to a Participant sustained while under the influence of illegal drugs, unless such Injuries are the result of a medical condition;

33. Habilitative, education, or training services or supplies for dyslexia and for disorders or delays in the development of a child's language, cognitive, motor or social skills. However, this exclusion does not apply to evaluations or treatment of developmental disabilities in children under age seven (7) as stated under the Neurodevelopmental Therapy Benefit;

34. Any care connected with a dependent child’s Pregnancy, except care furnished for the treatment of a complication of Pregnancy;

35. Private duty nursing;

36. Care rendered by any medical facility that is owned or operated by a government agency, except when the Plan refers you to the facility, the facility’s covered services are to treat a medical Emergency or an accidental Injury that is treated within 72 hours of the Injury, or when the Plan is required by law to provided available benefits for covered services rendered by the facility;

37. Services and supplies to the extent that benefits are payable under the terms of any contract or insurance offering, including, but not limited to, motor vehicle medical, motor vehicle no-fault, or other personal Injury protection (PIP) coverage and commercial premises or homeowner's medical premises coverage, or similar type of coverage or insurance. Any benefits provided by this Plan contrary to this Exclusion are provided solely to assist the Covered Person. By providing such benefits, this Plan is not waiving any right to reimbursement, recovery, or to subrogation as provided in this Plan;

38. Services and supplies that are payable by any public program, government, foundation, or charitable grant, except as otherwise required by law;

39. Pre-Existing Conditions. Coverage will be provided for Covered Expenses for Pre-Existing Conditions after the Pre-Existing Condition Waiting Period ends;

40. Air travel, transportation by private automobiles or taxi service or other ground transportation, whether or not recommended by a Physician, except as provided herein under the Ambulance benefit;

41. Sanitarium or rest cures;

42. Charges for services incurred as a result of a court order;

43. Any services or supplies that are not specifically listed as a benefit of this Plan.

PRE-EXISTING CONDITIONS

Claims resulting from Pre-Existing Conditions are excluded from coverage under the Plan except as specified below.

The Pre-Existing Condition limitation for a Covered Person will no longer apply after a period of three (3) consecutive months following the Covered Person's Enrollment Date. All eligible charges incurred after this three-month Pre-Existing Condition Waiting Period will be considered eligible.

"Pre-Existing Condition" is a physical or mental condition, regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received within three (3) months prior to the person's Enrollment Date under this Plan. Genetic Information is not a Pre-Existing Condition in the absence of a diagnosis of the condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines.

EXCEPTION(s) TO THE PRE-EXISTING CONDITION WAITING PERIOD

1. Length of coverage under the prior Association-sponsored health plan will be automatically credited towards this Plan's Pre-Existing Condition Waiting Period.

~~1.~~2. The Pre-Existing Condition Waiting Period does not apply to Pregnancy or to Newborns enrolled within sixty (60) days of birth or children adopted or placed for adoption before attaining age 18 who are enrolled within sixty (60) days of placement or adoption.

~~2.~~3. The length of the Pre-Existing Condition Waiting Period may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan, provided there has not been a significant "break in coverage" between prior Creditable Coverage and the individual's Enrollment Date in this Plan. That is, so long as the person did not have a significant break in coverage (i.e., 63 or more consecutive days during which an individual does not have any Creditable Coverage), then one day from this Plan's Pre-Existing Condition Waiting Period will be subtracted for each day of Creditable Coverage from the other health plan. The eligibility waiting period does not count as a "break in coverage." All other Plan terms and limits still apply.

Thus, in order to determine the length of an eligible person's Pre-Existing Condition Waiting Period for purposes of this Plan, an eligible person will need to request a certificate of Creditable Coverage from his or her prior plan. The Claims Administrator will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan if he or she is experiencing difficulty in obtaining a certificate. If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Condition Waiting Period imposed on that individual, that individual will be so notified.

The Plan will provide a certificate of Creditable Coverage to Participants and dependents covered under the Plan as required by HIPAA at the following times:

- With respect to qualified beneficiaries who are entitled to elect COBRA continuation coverage, at the time they lose coverage under a plan in the absence of COBRA continuation coverage or alternative coverage.
- With respect to individuals who are not qualified beneficiaries under COBRA, at the time they cease to be covered under the Plan.
- With respect to qualified beneficiaries who elect COBRA continuation coverage, at the time the individual's coverage ends under COBRA.
- Upon a Participant's (or his or her spouse's or dependent's) request, if such request is made within 24 months after the individual loses coverage under the Plan.

PRE-NOTIFICATION OF HOSPITAL ADMISSION PROVISION

The pre-notification program helps the Claims Administrator to identify chronic Illnesses and catastrophic Injuries or disability for potential large case management. The Plan has contracted with Qualis Health to be its pre-notification clearinghouse.

PRE-NOTIFICATION OF INPATIENT HOSPITALIZATION

When your Physician recommends Hospitalization, you or your Physician must call Qualis Health as soon as possible but no later than 48 hours before the scheduled admission. Qualis Health only needs to be notified of Inpatient Hospitalizations. It is important to note that this telephone call is for the purpose of notice only; no approval or denial of the treatment will be made.

The telephone numbers for Qualis Health are in Seattle, (206) 364-9700 and outside Seattle (800) 783-8606.

EMERGENCY HOSPITALIZATION

If Emergency Hospitalization is necessary, you, a Family member, your Physician or the Hospital must contact Qualis Health within 48 hours following admission.

If you call Qualis Health on the weekend or at night, you should leave a message on the voice mail answering machine. Your message should include:

- Your name
- Patient's name, if other than you
- Identify yourself as a Washington Fire Commissioners Association plan Participant
- Telephone number where you or a Family member can be reached
- Name of Hospital where patient is being admitted
- Reason for Hospital admission
- Date of admission

MEDICAL CASE MANAGEMENT

This Plan may provide case management services to address chronic Illnesses and catastrophic Injuries or disabilities. The case manager cooperates with you and the entire health care team to promote quality of care and the best use of your health care dollars.

The case manager assesses information from you, your Family, and your Physician to develop a formal treatment plan to meet your specific Medically Necessary and appropriate needs. This Plan outlines specific goals and suggests alternative treatments to achieve them, if appropriate. All treatments are closely monitored by the case manager to ensure that the service is appropriate and cost-effective. This allows you to get the most from your health care dollars without compromising the quality or integrity of your care.

PRESCRIPTION DRUG PLAN

Benefits for Outpatient prescription drugs are provided in three (3) ways:

1. Employees and their eligible dependents may purchase prescription drugs at Express Scripts member pharmacies by showing their ID card. Participants will be required to pay the applicable Copayment (as stated in the Prescription Drug Summary of Benefits) at the time of purchase for covered prescriptions, subject to the Limitations and Exclusions set forth below. Purchases are limited to a 34-day supply (a 60-day supply may be purchased, subject to two [2] Copays). A 34-day supply or 100 tablets or capsules (whichever is greater) is available for certain maintenance medications for a single Copay. Not all medications taken on an ongoing basis are part of this benefit – only those on the Maintenance Medication List.

2. Employees and their eligible dependents that purchase prescription drugs from non-member pharmacies or that fail to use their ID Card must pay the cost of the prescription in full and file a claim for reimbursement directly with Express Scripts (less the applicable Coinsurance stated in the Prescription Drug Summary of Benefits).

3. Employees and their eligible dependents may purchase prescription drugs through the Certifax, the mail order pharmacy vendor, subject to the applicable Copayment (as stated in the Prescription Drug Summary of Benefits) for covered prescriptions. Eligible prescriptions will be mailed directly to the Participant's home with an invoice for the Copayment (added). Mail order prescriptions are limited to a 90-day supply.

OUTPATIENT PRESCRIPTION DRUG LIMITATIONS

This Plan requires that unless your Physician states that a Brand Name is Medically Necessary, a Generic Drug will be dispensed. If your Physician authorizes a Generic Drug prescription and you elect to receive a Brand Name Drug, you will be required to pay the difference in cost between the Generic Drug and Brand Name Drug.

Benefits for Outpatient prescription drugs are provided at a constant benefit amount and do not increase to 100% and do not apply to the deductible or out-of-pocket maximum.

For secondary coverage on Prescription Drugs, claims should be submitted to the Claims Administrator (TPSC).

The Outpatient prescription drug benefit includes, but is not limited to::

A. Drugs requiring a prescription, subject to the Medical Plan Limitations and Exclusions of the Plan.
B. Insulin and insulin syringes.
C. Prenatal vitamins.
D. Oral and injectable contraceptives.

The following are excluded:

A. Investigational or experimental drugs, including compounded medications for non-FDA approved use.
B. Drugs intended for use in a Physician's office or another setting other than home use.
C. Therapeutic devices or appliances, support garments and other non-medical substances, Rogaine, anorexients (weight loss medications), non-prenatal prescription vitamins, fertility medications, medications for sexual dysfunction, drugs with cosmetic indications, Retin-A for individuals over age 26, steroids for body building, over the counter medications, and replacement of lost or stolen prescriptions.

VISION PLAN

The following are vision benefits under this program, which are subject to the Vision Plan Limitations and Exclusions shown below. Services may be received from the provider of your choice.

COVERED VISION SERVICES

- Eye examination. "Eye examination" consists of the inspection of internal and external appearance of the eye, eye movement, visual acuity, visual field, color vision, glaucoma and a refraction test, to assess whether glasses or contact lenses are necessary.
- Single vision, bifocal and trifocal lenses.
- Contact lenses.
- Frames.

VISION PLAN LIMITATIONS

1) Exam is limited to one (1) per Calendar Year. Fittings for contact lenses are covered under the materials benefit allowance as shown in the Vision Summary of Benefits.

2) Lenses and frames are limited to the materials benefit allowance shown in the Vision Summary of Benefits.

3) Prescription sunglasses are provided only when visual correction is necessary.

4) Surgically implanted contact lenses, aphakic or lenticular lenses will be paid under the materials benefit allowance, with the balance to the Durable Medical Equipment and Supplies Benefit if such treatment is Medically Necessary.

5) Covered is limited to services provided by optometrists, ophthalmologists and opticians, to the extent that such services are within the scope of their license.

VISION PLAN EXCLUSIONS

1) Charges for special procedures, such as orthoptics or vision training, or for special supplies, such as non-prescription sunglasses and subnormal vision aids.

2) Drugs or medications of any kind.

3) Charges for services or supplies which are received while the individual is not covered.

4) Charges for any vision care services or supplies which are included as Covered Expenses under any other benefit section in this Plan.

5) Charges for vision care services or supplies for which benefits are provided under any Workers' Compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges.

6) Charges for any eye examination required by an employer as a condition of employment or which an employer is required to provide under a labor agreement, or which is required by any law or government.

CLAIMS PROCEDURES

The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of health benefits under this Plan.

HEALTH CLAIMS

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are three types of claims: Pre-service (Urgent and Non-urgent) which apply to transplants only, and Post-service.

PRE-SERVICE CLAIMS

A "Pre-service Claim" is a claim for transplant benefits under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" is any claim for transplant benefits with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A Pre-service Claim is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator and includes the following information:

1. The proposed date of service;
2. The name, address, telephone number and tax identification number of the proposed provider of the services or supplies;
3. The proposed place where the services are to be rendered;
4. The diagnosis and procedure codes;
5. The anticipated amount of charges;
6. The name of the Plan or group number;
7. The name and Social Security Number of the covered Employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 48 hours from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

POST-SERVICE CLAIMS

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

A Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan or group number;
7. The name and Social Security Number of the covered Employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

WHEN HEALTH CLAIMS MUST BE FILED

Health claims must be filed with the Claims Administrator within 12 months of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.** However, on termination of the Plan, final claims must be received within ninety (90) days of termination.

TIMING OF CLAIM DECISIONS

The Plan shall notify the claimant, in accordance with the provisions set forth below, of any benefit determination (and, in the case of Pre-service Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Urgent Care Claims:

- If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
- If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be asked to supply the information within 48 hours. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Pre-service Non-urgent Care Claims:

- If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be asked to supply the needed information within 45 days. The claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period. In that case, the claimant will be notified of the determination by a date agreed to by the Plan and the claimant.

Post-service Claims:

- If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the claimant has not provided all of the information needed to process the claim then the claimant will be notified as to what specific information is needed as soon as possible, but no later than 30 days after receipt of the claim. The claimant will be asked to supply the needed information within 45 days. The claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period. In that case, the claimant will be notified of the determination by a date agreed to by the Plan and the claimant.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims. Extensions – Pre-service Non-urgent Care Claims. The 15-day processing period may be extended by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims. The 30-day processing period may be extended by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION

The Plan shall provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Plan upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures;
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and
9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Full and Fair Review of All Claims: In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an individual employed by the Claims Administrator or an individual employed by the Plan Administrator, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Claims Administrator (for the first appeal) or the Plan Administrator (for the second appeal) shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
7. That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits in possession of the Plan Administrator or the Claims Administrator, information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and
8. In an Urgent Care Claim, for an expedited review process pursuant to which
   - A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
   - All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

FIRST APPEAL LEVEL

Requirements for First Appeal: The claimant must file the first appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) with the Claims Administrator (who will perform the benefit determination on First Appeal) within 180 days following receipt of the notice of an adverse benefit determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, the claimant may telephone the Claims Administrator as follows: Claims Manager, 1-800-426-9786, Ext. 211. To file an appeal in writing, the claimant's appeal must be mailed to the address as follows or faxed to the following number: Trusteed Plans Service Corporation, 6901 – 6th Avenue, Tacoma, WA 98406, FAX number: 253-564-5881 ATTN: Claims Manager.

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/claimant;
2. The Employee/claimant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal**;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal: The Plan shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the appeal.

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal: The Plan shall provide a claimant with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;
7. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan's review procedures and the time limits applicable to the procedures;
9. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims; and
10. The following statement: "All claim review procedures provided for in the Plan must be exhausted before any legal action is brought."

Furnishing Documents in the Event of an Adverse Determination: In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

SECOND APPEAL LEVEL

Adverse Decision on First Appeal; Requirements for Second Appeal: Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the claimant has 60 days to file with the Plan Administrator a second appeal of the adverse decision. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's second appeal must be in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) as described in the section entitled "Requirements for First Appeal" and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal: The Plan shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the second appeal.

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal: The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; (ii) a description of the Plan's review procedures and the time limits applicable to the procedures; and (iii) for Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claim. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination: In the case of an adverse benefit determination on the second appeal, the Plan shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Second Appeal to be Final: If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate Named Fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within three (3) years after the Plan's claim review procedures have been exhausted.**

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a particular benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form, if deemed appropriate by the Plan Administrator or the Claims Administrator.

GENERAL PROVISIONS

ALTERNATE BENEFITS

Alternate benefits means payment for those services or supplies which are not otherwise Covered Expenses of the Plan, but that the Claims Administrator believes to be Medically Necessary and cost-effective. If payment for alternate benefits is approved by the Claims Administrator, the Covered Person will be notified of such approval and the duration of such approval.

The fact that alternate benefits are paid by the Plan shall not obligate the Plan to pay such benefits for other Covered Persons, nor shall it obligate the Plan to pay continued or additional alternate benefits for the same Covered Person. Payments for alternate benefits are Covered Expenses for all purposes under the Plan.

EXAMINATION

If necessary to assist in making a benefit determination, the Plan may request that the patient be examined by a doctor selected and paid by the Plan. If the patient chooses not to comply with this request, benefits will be denied.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan with respect to Covered Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

TIME LIMITATION

If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by the law of the state in which the Plan is existent, such limitation is hereby extended to agree with the minimum period permitted by such law.

FREE CHOICE OF PROVIDER

The Covered Person shall have free choice of any legally qualified Physician and/or Licensed Health Care Provider and the provider-patient relationship shall be maintained.

WORKER'S COMPENSATION NOT AFFECTED

This Plan does not affect any requirement for and is not in lieu of coverage provided by Worker's Compensation Insurance.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby deemed amended to conform to the minimum requirements thereto.

STATEMENTS

In the absence of fraud, all statements made by a Covered Person will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

MISCELLANEOUS

Section titles are for conveniences of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan or Plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, this Plan will be fully discharged from liability.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

COORDINATION WITH MEDICARE

Notwithstanding all other provisions of this Plan, all Covered Persons who are eligible for Medicare benefits, will be entitled to benefits under this Plan in addition to Medicare.

This Plan will be primary (i.e., pays benefits before Medicare) in the following circumstances:

- For an Employee (NOT Retiree) who is on Medicare because of age;
- For a spouse (NOT the spouse of a retiree) who is on Medicare because of age;
- For an Employee (NOT Retiree) who is on Medicare because of an SSA Disability -AND- who is considered to be in "current employment status" as defined by Medicare;
- For a spouse (NOT the spouse of a retiree) who is on Medicare because of an SSA Disability;
- For the first thirty* (30) months of Medicare Coverage for ANY Employee, Retiree, Employee's spouse, Retiree's spouse who is on Medicare because of End-Stage Renal Disease (ESRD) - AND ONLY if the individual was not FIRST on Medicare for a reason that would make Medicare Primary.

* Up to 33 months depending on when dialysis commences

This Plan will be secondary (i.e., pays benefits after Medicare) in the following circumstances:

- For a Retiree or Retiree's spouse who is on Medicare because of age;
- For a Retiree or Retiree's spouse who is on Medicare because of SSA Disability;
- Only after thirty* (30) months of Medicare Coverage for ANY Employee, Retiree, Employee's spouse, Retiree's spouse who is on Medicare because of End-Stage Renal Disease (ESRD).

* Up to 33 months depending on when dialysis commences

When this Plan is secondary to Medicare, the Plan will coordinate benefits (i.e. reduce this Plan's benefits in most circumstances) by the amount Medicare would have paid, even if the person is not enrolled under Medicare (Part A and/or Part B).

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Benefits Subject to This Provision This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies A Participant may incur medical or other charges related to Injuries or Illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Illness. If so, the Participant may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Participant may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supercedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Participant procures or may be entitled to procure regardless of whether the Participant has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Participant agrees that acceptance of benefits is constructive notice of this provision.

The Participant must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;

2. Authorize the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Participant's rights to Recovery when this provision applies;

3. Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for

other Illnesses or Injuries), the Participant will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness. If the Plan pays any medical or other benefits for the Injuries or Illness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement ***Any amounts recovered will be subject to Subrogation or Reimbursement***. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

"Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Participant's Injuries or Illness.

"Another Party" shall include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Participant's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery" shall mean any and all monies paid to the Participant by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

"Subrogation" shall mean the Plan's right to pursue the Participant's claims for medical or other charges paid by the Plan against Another Party.

"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses incurred by the Plan in collecting this benefit amount.

When a Participant Retains an Attorney If the Participant retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Participant's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Participant's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Participant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.
A Participant or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Participant or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Participant or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Participant is a Minor or is Deceased These provisions apply to the parents, trustee, guardian or other representative of a minor Participant and to the heir or personal representative of the estate of a deceased Participant, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Participant Does Not Comply When a Participant does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Participant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce this provision, then that Participant agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

COORDINATION OF BENEFITS

The coordination of benefits provision is intended to prevent the payment of benefits which exceed Allowable Expenses. It applies when the Participant or any eligible dependent who is covered by the Plan is also covered by any other plan or plans. When more than one coverage exists, one Plan normally pays its benefits in full and the other plans pay reduced benefits. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed one hundred percent (100%) of Allowable Expenses. Only the amount paid by the Plan will be charged against the Plan maximums.

The coordination of benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

COORDINATION OF BENEFITS DEFINITIONS

"Plan" as used in this Section will mean any plan providing benefits or services for or by reason of medical, dental or vision treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group, whether on an insured or uninsured basis, including but not limited to:

    a. Hospital indemnity benefits; and
    b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims;

2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;

3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;

4. A licensed Health Maintenance Organization (H.M.O.);

5. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

6. Any coverage under a governmental program, and any coverage required or provided by any statute; or

"Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

"Allowable Expenses" means any necessary item of expense, the charge for which is Usual, Reasonable and Customary, at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a Calendar Year or that portion of a Calendar Year during which the Covered Person for whom claim is made has been covered under this Plan.

COORDINATION ORDER OF BENEFIT DETERMINATION

Certain rules are used to determine which of the Plans will pay benefits first. This is done by using the **first** of the following rules which applies:

1. A Plan with no coordination provision will determine its benefits before a Plan with a coordination provision.

2. A Plan that covers a person other than as a dependent will determine its benefits before a Plan that covers such person as a dependent.

3. When a claim is made for a dependent child who is covered by more than one Plan, the benefits as a dependent of the parent whose birthday falls earlier in the Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that year; except

    a. If both parents have the same birthday, the benefits of the Plan which covers the parent longer are determined before those of the Plan which covers the other parent for a shorter period;

b. If the other Plan does not have the rules stated in (3), but instead has the rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rules in the other Plan will determine the order of benefits.

4. When the parents of a dependent child are divorced or separated, these are the rules for determining which Plan pays first:

   a. The Plan of the parent with custody;
   b. Plan of the spouse of the parent with custody;
   c. Plan of the parent without custody; and
   d. Plan of the spouse of the parent without custody.

5. When the parents of a dependent child are divorced or separated and there is a decree establishing financial responsibility for medical expenses of the dependent child, benefits as a dependent of the parent with financial responsibility are determined before benefits as a dependent of the parent without financial responsibility.

6. A Plan that covers a person as a laid off Employee, a retired Employee or a dependent of such Employee will determine its benefit after the Plan that does not cover such person as a laid off Employee, a retired Employee or a dependent of such Employee. If one of the Plans does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

7. When the above rules do not establish an order, benefits are determined first under the Plan that covers the person for the longest period of time.

EXCHANGE OF INFORMATION

This Plan and other Plans may exchange information needed in order to coordinate benefits. No consent or notice is required. Covered Persons must furnish needed information.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator (the Washington Fire Commissioners Association). The Plan Administrator has retained the services of the Claims Administrator to provide certain claims processing and other technical services.

Plan Administrator An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

Duties of the Plan Administrator The duties of the Plan Administrator include the following:

- To administer the Plan in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the Plan;
- To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a Participant's rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain documents and all other records pertaining to the Plan;
- To appoint and supervise a third party administrator to pay claims;
- To perform all necessary reporting as required by applicable law;
- To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan This document contains all the terms of the Plan and may be amended from time to time by the Association. Any changes shall be by an approved motion of the WFCA Insurance Rate Stabilization Reserve Account (IRSRA) Committee and shall become effective as of the date specified. A certified copy of any amendment shall be furnished to the Claims Administrator and to any other outside provider of plan administration services. Any such amendment so made shall be binding on each Participant and on any other Covered Persons referred to in this document.

The Association shall notify all covered Participants of any amendment modifying the substantive terms of the Plan as soon as is administratively feasible.

The Association reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions made by participating fire protection districts shall continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or shall be distributed to the Association or any successor association, authorized by RCW 52.08.030(5) for like purposes for use in any program with similar purposes, until all contributions are exhausted.

DEFINITIONS

The following words and phrases shall have the following meanings when used in this document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this document for that information.**

ALCOHOLISM

"Alcoholism" means a morbid state caused by excessive and compulsive consumption of alcohol that interferes with the patient's health and social or economic functioning.

ALCOHOLISM TREATMENT CENTER OR DRUG ADDICTION TREATMENT FACILITY Revised

"Alcoholism Treatment Center" or "Drug Addiction Treatment Facility" is a treatment facility that is approved by the Washington State Department of Social and Health Services (or another state) for treatment of Alcoholism or drug addiction

This does not include recovery houses, residential crisis treatment centers or residential treatment facilities that provide an alcohol-free or drug-free residential setting.

ALVEOLAR

“Alveolar” means pertaining to the ridge, crest or process of bone which projects from the upper and lower jaw and supports the roots of the teeth.

AMBULANCE

"Ambulance" means a specifically designed and equipped automobile or other vehicle such as an airplane, boat or helicopter which meets all local, state and federal regulations for transporting the sick and injured.

AMBULATORY SURGICAL CENTER

"Ambulatory Surgical Center" means an institution or facility, either free standing or as part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or Dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered to be an Ambulatory Surgical Center.

ASSOCIATION

“Association” means the Washington Fire Commissioners Association.

BENEFIT PERIOD

"Benefit Period" refers to a time period of one (1) year, as shown on the Medical Summary of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one (1) year period so established;
2. The day the Lifetime Maximum Benefit applicable to the Covered Person is reached; or
3. The day the Covered Person ceases to be covered for benefits of this Plan.

BENEFIT YEAR

"Benefit Year" means a Calendar Year.

BRAND NAME DRUG

“Brand Name Drug” means a drug manufactured by a pharmaceutical company which has chosen to patent the drug's formula and register its brand name.

CALENDAR YEAR

"Calendar Year" means a period of time commencing on January 1 and ending on December 31 of the same given year.

CLAIMS ADMINISTRATOR

"Claims Administrator" means Trusteed Plans Service Corporation, the firm retained by the Plan Administrator, who is responsible for performing certain ministerial functions for the Plan, including but not limited to enrollment, premium collecting and claims processing and reporting.

CLOSE RELATIVE

"Close Relative" means the spouse, parent, brother, sister, child, aunt, uncle or grandparent of the Covered Person or the Covered Person's spouse.

COBRA

"COBRA" means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COPAY / COPAYMENT

A Copay or Copayment is an amount a Covered Person pays at the time of service (these are listed in the Medical and Prescription Drug Summary of Benefits).

COSMETIC PROCEDURE

"Cosmetic Procedure" means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the restoration of bodily function.

COVERED EXPENSES

"Covered Expenses" means the Usual, Customary and Reasonable charges for Necessary or Medically Necessary treatments, services, or supplies that are listed as a covered benefit of the Plan..

COVERED PERSON

"Covered Person" means any Participant or dependent of a Participant meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

CREDITABLE COVERAGE

“Creditable Coverage” shall mean prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

CUSTODIAL CARE

"Custodial Care" means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DENTIST

"Dentist" means a person duly licensed to practice Dentistry by the governmental authority having jurisdiction over the licensing and practice of Dentistry in the locality where the service is rendered.

DEPENDENT COVERAGE

"Dependent Coverage" means eligibility under the terms of the Plan for benefits payable as a consequence of Covered Expenses incurred for an Illness or Injury of a properly enrolled dependent.

DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" means equipment that is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

EMERGENCY

"Emergency" means an Illness or Injury of sudden, acute onset resulting in a life-threatening situation requiring immediate Physician and Hospital attention. Examples of a medical Emergency are heart attacks or suspected heart attacks, coma, loss of respiration, stroke, acute appendicitis, etc.

EMPLOYEE

See definition of Covered Person.

EMPLOYER

“Employer” means participating fire protection districts.

ENROLLMENT DATE

"Enrollment Date" is the first day of coverage or, if earlier and there is an eligibility waiting period for benefits, the first day of the eligibility waiting period. However, the Enrollment Date for an individual who enrolls under a Special Enrollment Provision under this Plan will be the first date of coverage.

EXCLUSIONS

“Exclusions” means services not provided under this Plan.

EXPERIMENTAL AND/OR INVESTIGATIONAL

The Plan Administrator or its designee has the discretion and authority to determine if a medical, surgical, diagnostic, psychiatric, substance abuse or other health care service, technology, supply, treatment, procedure, drug therapy or device is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for preauthorization under the Plan’s utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
2. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, or scientific literature on the subject, or a preponderance of such literature published in the United States and written by experts in the field; that shows that recognized medical or scientific experts classify the service or supply as Experimental and/or Investigational or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.

    - authoritative peer reviewed medical or scientific writings that will be considered include the following publications or sources of publications:
    - “United States Pharmacopoeia Dispensing Information”;
    - “American Hospital Formulary Service”;
    - “American Medical Association (AMA), Drug Evaluations” and “The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, or similar publications of the AMA;
    - specialty organizations recognized by the AMA;
    - the National Institutes of Health (NIH);
    - the Center for Disease Control (CDC);
    - the Agency for Health Care Policy and Research (AHCPR)
    - opinions of other agency review organization, e.g. ECRI Health Technology Assessment Information Service or HAYES New Technology Summaries;
    - the American Dental Association (ADA), with respect to dental services or supplies;
    - the latest edition of “The Medicare Coverage Issues Manual.”

3. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is approved by the FDA as an "investigational new drug for treatment use"; or classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term in defined in FDA regulations; or approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
4. The prescribed service or supply is available to the Covered Individual only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

FAMILY

"Family" means a Participant and his eligible dependents.

GENERIC DRUG

"Generic Drug" is a drug that is generally equivalent to a higher-priced Brand Name Drug that meets all FDA bioavailability standards.

GENETIC INFORMATION

"Genetic Information" means information about genes, gene products, and inherited characteristics that may derive from an individual or a Family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, Family histories and direct analysis of genes or chromosomes.

HOME HEALTH CARE AGENCY

"Home Health Care Agency" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one Registered Nurse to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse.
3. It maintains a complete medical record on each individual.
4. It has a full-time administrator.

HOME HEALTH CARE PLAN

"Home Health Care Plan" means a program for continued care and treatment of the Covered Person established and approved in writing by the Covered Person's attending Physician. The attending Physician must certify that the proper treatment of the Illness or Injury would require confinement as a resident Inpatient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan.

HOSPICE

"Hospice" means a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPITAL

"Hospital" means an institution that meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;

2. It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to Hospitals;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury;
4. Such treatment is provided for compensation by or under the supervision of Physicians with continuous twenty-four (24) hour nursing services by Registered Nurses;
5. It qualifies as a Hospital, a psychiatric Hospital, or a tuberculosis Hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
6. It is a provider of services under Medicare; and
7. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES

"Hospital Miscellaneous Expenses" means the actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

ILLNESS

"Illness" means a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

INCURRED EXPENSES

"Incurred Expenses" means charges for those services and supplies rendered to a Covered Person. Such expenses shall be considered to have occurred at the time or date the service or supply is actually provided. With respect to a course of treatment or procedure that includes several stages or phases of treatment, Covered Expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

INJURY

"Injury" means a condition caused by accidental means that results in damage to the Covered Person's body from an external force. Any loss which is caused by or contributed to by a hernia of any kind will be considered a loss under the definition of illness, and not as a loss resulting from accidental injury .

INPATIENT

"Inpatient" refers to the classification of a Covered Person when that person is admitted to a Hospital, Hospice, or Skilled Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment.

INTENSIVE CARE UNIT

"Intensive Care Unit" means a section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;
2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

LICENSED PRACTICAL NURSE

"Licensed Practical Nurse" (L.P.N.) means an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LIMITATIONS

“Limitations” are restricting conditions, such as age, period of time covered, and waiting periods, under which an individual is covered.

MEDICALLY NECESSARY or MEDICAL NECESSITY

"Medically Necessary" or "Medical Necessity" means that, as determined by the Plan:

1. There is an Illness or Injury which requires treatment; and
2. The confinement, service or supply used to treat the Illness or Injury is:
   A. Required;
   B. Generally professionally accepted as the usual, customary and effective means of treating the Illness or Injury in the United States; and
   C. Approved by regulatory authorities such as the Food and Drug Administration.

Diagnostic x-ray and laboratory services are Medically Necessary when:

1. Performed due to definite symptoms of Illness or Injury; or
2. They reveal the need for treatment.

MEDICARE

"Medicare" means the programs established by Title I of Public Law 89-98 (79 Statutes 291) as amended entitled "Health Insurance for the Aged Act", and which includes Parts A and B and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79), as amended from time to time.

MINOR EMERGENCY MEDICAL CLINIC

"Minor Emergency Medical Clinic" means a free-standing facility which is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

NAMED FIDUCIARY

"Named Fiduciary" means the Association.

NEWBORN

"Newborn" refers to an infant from the date of his birth until the initial Hospital discharge or until the infant is ninety-six (96) hours old, whichever occurs first.

ORTHOPEDIC APPLIANCE

"Orthopedic Appliance" means a rigid or semi-rigid support used to restrict or eliminate motion in a diseased, injured, weak or deformed body member.

OUTPATIENT

"Outpatient" refers to the classification of a Covered Person when that Covered Person received medical care, treatment, services or supplies at a clinic, a Physician's office, or at a Hospital if not a registered bed patient at that Hospital, an Outpatient Psychiatric Facility or an Outpatient Alcoholism Treatment Facility.

PARTICIPANT

"Participant" means the following who meet the qualifications as outlined in the Eligibility section of this Plan: a person employed in the regular business of and compensated for services by a participating fire protection district, WFCA staff and Fire Commissioners.

PARTICIPANT COVERAGE

"Participant Coverage" means coverage hereunder providing benefits payable as a consequence of an Injury or Illness of a Participant.

PHYSICIAN AND/OR LICENSED HEALTH CARE PROVIDER

"Physician and/or Licensed Health Care Provider" means legally licensed medical or dental providers, including but not limited to: Advanced Registered Nurse Practitioner A.R.N.P., Alcohol Treatment and Drug Addiction Facility, Certified Nurse Midwife C.N.M. if an A.R.N.P./C.N.M., Audiologists, Birthing Centers, Chiropractor D.C., Community Mental Health Center including those persons with the designation M.S.W., Dentist D.D.S. or D.M.D., Dietician D., C.D., or R.D., Durable Medical Equipment Supplies, Home Health Agency, Home Infusion Therapist, Hospice, Hospital, Laboratory, Licensed Practical Nurse L.P.N., Occupational Therapist O.T., Optometrist O.D., Physical Therapist P.T., Physician and Surgeon M.D. or D.O., Podiatrists D.P.M., Psychologist, Radiologic Technologists, Registered Nurse R.N., Respiratory Care Practitioners, Skilled Nursing Facility, Speech Therapist S.T., Surgical Assistant R.N. and Ambulatory Surgical Centers, to the extent that same, within the scope of their license, are **permitted to perform services provided in this Plan.**

A Physician and/or Licensed Health Care Provider shall not include the Covered Person or any Close Relative of the Covered Person.

PLAN

"Plan" means this Washington Fire Commissioners Association Health Care Benefits Plan.

PLAN SPONSOR

"Plan Sponsor" means the Washington Fire Commissioners Association.

PRE-EXISTING CONDITION

"Pre-Existing Condition" is a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within three (3) months prior to the person's Enrollment Date under this Plan. Genetic Information is not a Pre-Existing Condition in the absence of a diagnosis of the condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines.

PREFERRED PROVIDER

"Preferred Provider" shall mean a provider who has signed a Preferred Participant Agreement with a Preferred Provider Organization that has been contracted by the Plan or any other reciprocal provider network. These participating Physicians and Hospitals have agreed to offer their services at special rates to enrollees of this Plan.

PREFERRED PROVIDER SERVICE AREA

Preferred Provider Service Area as defined by the Plan Administrator:

1. If the Participant, or his covered Family member, do not reside within the Preferred Provider Service Area and services are received from a non-Preferred Provider, benefits will be provided as if the services of a Preferred Provider has been used.

2. If the Participant, or his covered Family member, reside within the Preferred Provider Service Area and services are obtained from a non-Preferred Provider, benefits will be provided at the non-Preferred Provider level unless:

    a) The claimant has traveled outside of the Preferred Provider Service Area and Emergency medical services are required;
    OR
    b) There is no Preferred Provider facility within the Preferred Provider Service Area which is able to render a Medically Necessary treatment. If this is the case, documentation must be provided and is subject to approval of the Claims Administrator.
    OR
    c) The claimant is transported by Ambulance or other Emergency medical personnel to the nearest medical facility equipped to render Medically Necessary care due to medical Emergency. If this is the case, documentation must be provided and the claimant must be transferred to a Preferred Provider facility as soon as medically possible.

3. Services of non-Preferred Providers will be processed as if a Preferred Provider had been used, if the Participant or his covered Family member:

    a) uses the services of a Preferred x-ray facility who subsequently uses a non-Preferred radiologist for reading the x-

ray;

b) uses the services of both a Preferred facility and a Preferred surgeon and receives services from a non-Preferred anesthesiologist;

c) uses the services of both a Preferred facility and a Preferred surgeon and receives services from a non-Preferred assistant surgeon;

d) in the case of a medical Emergency, uses a Preferred facility and receives care from a non-Preferred urgent care clinic that is affiliated with that facility; or

e) in the case of a medical Emergency, uses a Preferred facility and receives care from a non-Preferred surgeon, anesthesiologist or other ancillary provider.

PREGNANCY

"Pregnancy" means that physical state which results in childbirth, abortion, or miscarriage.

PROSTHETIC APPLIANCE

"Prosthetic Appliance" means a device or appliance that is designed to replace a natural body part lost or damaged due to sickness or Injury, the purpose of which is to restore full or partial bodily function or appearance, or in the case of covered dental expenses, shall mean any device which replaces all or part of a missing tooth or teeth.

PSYCHIATRIC CARE

" Psychiatric Care", also known as psychoanalytic care, means treatment for a mental Illness or disorder, a functional nervous disorder, Alcoholism or drug addiction by a duly licensed psychiatrist, Psychologist, licensed social worker or licensed professional counselor acting within the scope and Limitations of their respective license, provided that such treatment is Medically Necessary, and within recognized and accepted professional psychiatric and psychological standards and practices..

PSYCHIATRIC FACILITY

"Psychiatric Facility" means an administratively distinct governmental, public, private or independent unit or part of such unit that provides Outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PSYCHOLOGIST

"Psychologist" means an individual holding the degree of Ph.D. and acting within the scope of his license.

QUALIFIED BENEFICIARY

"Qualified Beneficiary" means a covered Employee or dependent who was covered under the Plan prior to the COBRA qualifying event and who is eligible to continue coverage under the Plan in accordance with applicable provisions of COBRA due to a COBRA qualifying event. A Qualified Beneficiary includes a child born to the covered Employee or placed with the covered Employee for adoption if the covered Employee is covered under the Plan through COBRA Continuation of Coverage.

REGISTERED NURSE

"Registered Nurse" means an individual who has received specialized nursing training and is authorized to use the designation of "R.N.", and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

ROOM AND BOARD

"Room and Board" refers to all charges by whatever name called which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

SEMI-PRIVATE

"Semi-Private" refers to a class of accommodations in a Hospital or convalescent nursing facility in which at least two patients' beds are available per room.

SKILLED NURSING FACILITY

"Skilled Nursing Facility" means an institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;
2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse;
4. It maintains a complete medical record on each patient;
5. It has an effective utilization review plan;
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, education or Custodial Care, or care of mental disorders; and
7. It is approved and licensed by Medicare.

This term also applies to expenses incurred in an institution referring to itself as a convalescent nursing facility, extended care facility, convalescent nursing home, or any such other similar nomenclature.

TEMPOROMANDIBULAR JOINT

“Temporomandibular Joint” is the joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

USUAL, CUSTOMARY AND REASONABLE (UCR)

“Usual, Customary and Reasonable” is the lesser of the provider’s usual charge for the same services or supplies in the absence of insurance coverage and the charge customarily billed to private patients for the same or similar services or supplies by providers in the same geographic location (the same zip code region).

WELL-CHILD CARE

"Well-Child Care" means medical treatment, services or supplies rendered to a child through age 6 or a Newborn solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

PLAN INFORMATION

1. Name of Plan:
   Washington Fire Commissioners Association Health Care Benefits Plan

2. Type of Plan:
   Joint local government entities self-Funded Medical, Prescription Drugs and Vision Plan

3. Type of administration:
   Contract administration with the Claims Administrator. The funding for the benefits is derived from the funds of the Plan Sponsor (and contributions made by participating fire protection districts and covered Employees, if any). The Plan is self-funded.

4. Name, business address and telephone number of the Plan Sponsor:
   Washington Fire Commissioners Association
   P. O. Box 134
   Olympia, WA 98507
   (360) 943-3880

5. Name, business address and telephone number of the Plan Administrator and Named Fiduciary:
   Washington Fire Commissioners Association
   P. O. Box 134
   Olympia, WA 98507
   (360) 943-3880

6. Name and address for service of legal process:
   Same as shown in #5.

7. Name, business address and telephone number of the Claims Administrator:
   Trusteed Plans Service Corporation
   P.O. Box 1894
   Tacoma, Washington 98401-1894
   (253) 564-5850

8. Participating Employers: Participating Fire Protection Districts.